Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Use of this form is optional. A letter providing the same information is equally acceptable.

APPEAL FORM

(Use only to appeal your WRS coverage begin date or employment category.)

Please print or type.

EMPLOYEE INFORMATION	EMPLOYER INFORMATION
Social Security Number	Name
Name	Address
Mailing Address	
City, State, Zip	City, State, Zip

Under Wis. Stat. § 40.06 (1) (e), I hereby appeal the decision of my employer to the Employee Trust Funds Board regarding:

☐ My eligibility for participation in the Wisconsin Retirement System from _____ (date) to _____ (date).

An employee may appeal the employer's determination that the employee did not qualify as a participating employee directly to the Board if employment began prior to April 27, 1984. If employment began on or after April 27, 1984, Wis. Stat. § 40.06 (1) (e) may limit the appeal only to services rendered within seven years prior to the date the appeal is received by the Board.

☐ My employment category (general, executive, protective, teacher, elected official) from _____ (date) to _____ (date).

Employment category reported as _____.

I believe the correct category is _____.

An employee may appeal the employer's determination of employment category directly to the Board if employment began prior to January 1, 1982. If employment began on or after January 1, 1982, Wis. Stat. § 40.06 (1) (e) may limit the appeal only to service rendered within seven years prior to the date the appeal is received by the Board.

Please briefly explain the specific reasons for your appeal:

_____

_____

_____

_____

_____

Date (MM/DD/CCYY)	Signature
Position Title	Daytime Telephone Number

Return completed Appeal Form to: Department of Employee Trust Funds, Attn: Appeals Coordinator, P.O. Box 7931, Madison, WI 53707-7931.